

Application for Care

Please take a moment to fill out this form and sign the bottom.

Thanks! We will take GREAT care of you here!

Name (Print):				
Last Date of Birth	First Age	Gende	M er (Circle): Male o	or Female
Address		City	_ State Zi	p
Home Phone: Email	Cell : @_	SSN		
Number of Children Dccupation	Marital Status_ Employed b	Name of Spo	use	
Who may we thank for refe Have you ever had Chiropra	rring you to our office?actic Care? (Circle) Yes or N	o If yes, when was you	r last visit?	
Concern Sev	te in order of severity below) verity When did this 10= severe) episode start?	Have you had this condition before? When?	Did this start with an injury?	Is it a constant concern?
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3				
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	nditions have you seen another do	ctor?		
Please list any current cond	itions you have with the followin	ng systems:		
Skin (eczema, psoriasis, lupus	s, hives, etc.):			
//usculoskeletal (osteoporos	sis, rheumatoid arthritis, etc.):			
Cardiovascular (hypertension	n, high cholesterol, clotting disorde	ers, etc.):		
indocrine (diabetes, hypo/hy	perthyroidism, etc.):			
Respiratory (COPD, asthma,	etc.):			
Digestive (Irritable bowel, cor	nstipation, reflux, etc.):			
Jrinary (UTI, kidney stones, e	etc.):			
	v, ED, PCOS, etc.):			
mmune (allergies [please list]	, frequent colds, autoimmune disc	orders, etc.):		
ar, nose, throat (ear infectio	ons, chronic sinus issues, etc.):			
lervous (sciatica, multiple sc	elerosis, Parkinson's Diseases, etc.):		
Sensory and Psychological	(ADD/ADHD, anxiety, depression, a	autism, OCD, etc.):		



Please circle any condition you have currently or have had previously:

Stroke	Cancer	Heart Disease	Spinal Surgery	Seizures	Fracture	Scoliosis
Please list	any current me	dications, vitamins, ar	nd supplements (preso	cription or over t	ne counter):	
Please list	any previous su	urgeries or hospitaliza	tions and approximate	e date of occurre	ence:	
		taken? If so, please li	st area x-rayed, where	e they were take	n and approxim	nate date:
When was	your last auto a	accident?	Have	you ever been l	knocked uncons	scious?
		alth goals below!		•		
(ex. Get ric	Ith Goal: I of migraines)		Date to Accomplish: (8/2015)	(ex. I wa	Significance of ant to be able to acation this sun	golf on a fami
2				\ =		
3						
	Information: any type of Hea	alth Insurance? (Circle): Are you	Yes or No If covered by Medicare? Y	yes, Company: es or No		
	If ye	es, please give us your i	nsurance card so we cai	n photocopy it for	our files!	
		assume responsibilit onsent to be examin				
Patient						